

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

6124 63-044133
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

FILED DEC - 2 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY JACKSON | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY JOHNSON | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY | | c. CITY OR TOWN PRAIRIE VILLAGE | |
| Length of stay in lb 6 WEEKS | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) RESEARCH HOSPITAL | | d. STREET ADDRESS (If outside, give location) 2301 WEST 78TH STREET | |
| 3. NAME OF DECEASED (Type or print) First GEORGE Middle HENRY Last MEYER | | 4. DATE OF DEATH Month NOV. Day 9 Year 1963 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 1-4-1900 |
| 9. AGE (last birthday) 63 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MAN | 11. BIRTHPLACE (City and state or country) DALTON, Mo. | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13a. FATHER'S NAME WILLIAM MEYER | | 13b. MOTHER'S MAIDEN NAME ANNA ROHLFING | |
| 14. NAME OF HUSBAND OR WIFE KATHRYN MEYER | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) No | |
| 16. SOCIAL SECURITY NO. 375 | | 17. INFORMANT MRS. KATHRYN MEYER, 2301 W. 78TH ST. - PRAIRIE VILLAGE, MO. | |
| 18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Esophagus DUE TO (b) Post DUE TO (c) Esophagitis | | INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Esophagitis | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour 11 a.m. Month, Day, Year Nov 9 1963 | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION KANSAS CITY, MO. |
| 21. I attended the deceased from February 1963 to 9 Nov 1963 and last saw him alive on 8 November 1963 Death occurred at 4:15 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | 22. ADDRESS Kansas City 31, Mo | |
| 22a. SIGNATURE Warren Wilhelm, M.D. | | 22c. DATE SIGNED 11 Nov 1963 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE NOV-11-1963 | 23c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEM. | 23d. LOCATION (City, town, or county) (State) KANSAS CITY, MO. |
| 24. FUNERAL DIRECTOR D.W. NEWCOMERS SONS, K.C., MO. | | 25. DATE RECD. BY LOCAL REG. 11-11-63 | 26. REGISTRAR'S SIGNATURE Bessie Smith |

USE BLACK INK
OR
TYPEWRITER RIBBON

USE 2 - ONE COPY

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Verd Lawler

Licensed Embalmer No. 4915

P. O. Address K 6 MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Dr. Warren Fred Wilhelm
Reverend's Hospital - Marion - Indiana
Em 3-5225
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